



State of Wisconsin  
2017 - 2018 LEGISLATURE

LRB-0005/1  
AJM:klm

## 2017 SENATE BILL 778

February 7, 2018 - Introduced by Senators VINEHOUT, CARPENTER and RISSER, cosponsored by Representatives SARGENT, KOLSTE, VRUWINK, POPE, SUBECK, BERCEAU, CROWLEY, MURSAU and BERNIER. Referred to Committee on Insurance, Financial Services, Constitution and Federalism.

- 1 **AN ACT to create** 609.07 of the statutes; **relating to:** billing practices for certain  
2 health care providers and granting rule-making authority.

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### *Analysis by the Legislative Reference Bureau*

This bill creates disclosure, notice, billing, and mediation requirements for the situation in which a patient may receive services from a health care provider that is not in the network of the patient's defined network plan or preferred provider plan. Under the bill, a defined network plan or a preferred provider plan must annually provide to members of the plan a directory of providers that are in its network. The defined network plan or preferred provider plan must also provide its members a list of health care facilities that are in its network.

The bill also requires that a provider who is not in the network of the enrollee's defined network plan or preferred provider plan but is providing a service at an in-network health care facility must disclose that information to the enrollee, provide the enrollee a good-faith estimate of the cost of services the enrollee may be responsible for, and inform the enrollee of the availability of mediation to settle disputes over the cost of services. In particular, the enrollee is entitled to mediation for a claim if the amount that the enrollee is financially responsible for, after copayments, deductibles, and coinsurance, is more than \$500. The enrollee is not entitled to mediation if the out-of-network provider provides the required disclosure and the amount the enrollee is financially responsible for is less than the good-faith estimate provided by the provider. The health care facility may opt to provide the notice for the provider.

Under the bill, if an enrollee of a defined network plan or preferred provider plan requires medically necessary services that are not available from an

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in-network provider within a reasonable time, then the plan must provide an opportunity for referral to an out-of-network provider. The plan must reimburse the out-of-network provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may only require that the enrollee pay no more than the enrollee would have paid had the provider been in the plan's network. The bill requires the enrollee to provide the out-of-network provider an assignment of benefits for any service, item or supply provided by that provider.

Similarly, under the bill, if an enrollee of a defined network plan or preferred provider plan receives emergency services from an out-of-network provider, then the plan must reimburse the provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may only require the enrollee to pay no more than the enrollee would have paid if the provider was in the plan's network.

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*The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:*

1           **SECTION 1.** 609.07 of the statutes is created to read:

2           **609.07 Balance billing. (1) DEFINITIONS.** In this section:

3           (a) "Assignment of benefits" means a written instrument signed by an insured  
4           or the authorized representative of an insured that assigns to a provider the  
5           insured's claim for payment, reimbursement, or benefits under a disability  
6           insurance policy as defined in s. 632.895 (1) (a).

7           (b) "Emergency services" means those services required to treat and stabilize  
8           an emergency medical condition in accordance with 42 USC 1395dd and services  
9           originating in a hospital emergency department, a freestanding emergency  
10          department, or a similar facility following treatment or stabilization of an emergency  
11          medical condition.

12          (c) "Network" means the providers that are under contract with a defined  
13          network plan or preferred provider plan to provide services to enrollees at an agreed  
14          price, for which the provider receives reimbursement in accordance with the  
15          contract.

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1           **(2) NOTICE OF NETWORK STATUS.** (a) A a defined network plan or preferred  
2 provider plan shall provide, no less frequently than annually, a list of hospitals that  
3 have agreed to facilitate the usage of providers that are in the defined network plan's  
4 or preferred provider plan's network. The list shall specify the percentage of  
5 providers at those hospitals that are not in the defined network plan's or preferred  
6 provider plan's network.

7           (b) A defined network plan or preferred provider plan shall provide, no less  
8 frequently than annually, a directory of all providers that are in the defined network  
9 plan's or preferred provider plan's network that are under contract with health care  
10 facilities that are in the defined network plan's or preferred provider plan's network.  
11 In the directory, the defined network plan or preferred provider plan shall specify  
12 health care facilities that do not have contracts with providers in a particular  
13 specialty.

14           **(3) DISCLOSURES.** (a) A provider that is not in a defined network plan's or  
15 preferred provider plan's network and is under contract to provide services at a  
16 health care facility that is in the defined network plan's or preferred provider plan's  
17 network shall provide, in writing, to an enrollee of the defined network plan or  
18 preferred provider plan all of the following:

19           1. That the enrollee may receive services from a provider that is not in their  
20 defined network plan's or preferred provider plan's network.

21           2. A good faith estimate of the enrollee's financial responsibility for the services  
22 provided under subd. 1.

23           3. That the enrollee is entitled to mediation under circumstances described in  
24 sub. (6).

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1 (b) In lieu of the provider providing the notice under par. (a), a health care  
2 facility may provide the notice described under par. (a).

3 **(4) EMERGENCY SERVICES.** (a) If an enrollee of a preferred provider plan that  
4 restricts or increases cost sharing for use of providers that are not in its network  
5 obtains emergency services from a provider not in the preferred provider plan's  
6 network, the preferred provider plan shall do all of the following:

7 1. Allow the enrollee to obtain services from the provider until the enrollee can  
8 be transferred to a provider that is in the preferred provider plan's network in  
9 accordance with 42 USC 1395dd.

10 2. Reimburse the provider at the usual and custom rate or at a rate agreed to  
11 by the provider and the preferred provider plan.

12 3. Require the enrollee to pay an amount for the emergency services that is no  
13 more than the enrollee would have paid if the provider had been in the preferred  
14 provider plan's network.

15 (b) If an enrollee of a defined network plan obtains emergency services from a  
16 provider that is not in the defined network plan's network, the defined network plan  
17 shall do all of the following:

18 1. Reimburse the provider at the usual and customary rate or at a rate agreed  
19 to by the provider and the defined network plan.

20 2. Require the enrollee to pay an amount for the emergency services that is no  
21 more than the enrollee would have paid if the provider had been in the defined  
22 network plan's network.

23 **(5) MEDICALLY NECESSARY SERVICES.** If an enrollee of a defined network plan or  
24 a preferred provider plan that restricts or increases cost sharing for use of providers  
25 that are not in its network is unable to obtain medically necessary services within

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1 a reasonable time from a provider in the plan's network, the plan shall, upon the  
2 request of a provider that is in the plan's network, do all of the following:

3 (a) Within a reasonable time, allow referral to a provider that is not within the  
4 preferred provider plan's or defined network plan's network.

5 (b) Reimburse the provider that is not in the preferred provider plan's or  
6 defined network plan's network at the usual and customary rate or at a rate agreed  
7 to between the provider and the plan. The enrollee shall provide to the provider  
8 under this paragraph an assignment of benefits from the enrollee to the provider for  
9 any service, item, or supply that the provider provides to the enrollee.

10 (c) Require the enrollee to pay an amount for the medically necessary services  
11 that is no more than the enrollee would have paid if the provider had been in the  
12 preferred provider plan's or defined network plan's network.

13 **(6) MEDIATION.** (a) Except as provided under par. (b), an enrollee of a defined  
14 network plan or preferred provider plan shall be entitled to request mediation to  
15 resolve a claim if all of the following apply:

16 1. The provider is not in the network of the enrollee's defined network plan or  
17 preferred provider plan.

18 2. The provider is under contract to provide services at a health care facility  
19 that is generally in the network of the enrollee's defined network plan or preferred  
20 provider plan.

21 3. The enrollee is responsible for an amount, after copayments, deductibles,  
22 and coinsurance, that exceeds \$500.

23 (b) The enrollee is not entitled to request mediation if all of the following apply:

24 1. The provider or health care facility provided the notice under sub. (2).

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1           2. The amount that the enrollee is responsible for, after copayments,  
2 deductibles, and coinsurance, is less than the good faith estimate provided under  
3 sub. (3) (a) 2.

4           (c) The defined network plan or preferred provider plan shall include in an  
5 explanation of benefits statement provided to an enrollee a notice that the enrollee  
6 may be entitled to request mediation as provided under this subsection.

7           **(7) RULES.** The commissioner may promulgate rules to establish procedures for  
8 mediation under this section.

9           **(8) CONFLICTS.** To the extent that this section conflicts with s. 609.10, 609.91,  
10 or 609.92, this section supersedes ss. 609.10, 609.91, and 609.92.

11           **SECTION 2. Initial applicability.**

12           (1) (a) For plans or contracts containing provisions inconsistent with this act,  
13 the act first applies to plan or contract years beginning on January 1 of the year  
14 following the year in which this paragraph takes effect, except as provided in  
15 paragraph (b).

16           (b) For plans or contracts that are affected by a collective bargaining agreement  
17 containing provisions inconsistent with this act, this act first applies to plan or  
18 contract years beginning on the effective date of this paragraph or on the day on  
19 which the collective bargaining agreement is newly established, extended, modified,  
20 or renewed, whichever is later.

21           **SECTION 3. Effective date.**

22           (1) This act takes effect on first day of the 7th month beginning after  
23 publication.

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(END)